

LEARNING FROM DIFFERENCES IN THE UNITED STATES AND UNITED KINGDOM
HEALTHCARE SYSTEMS TO AVOID DISASTER

by

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Abstract

The purpose of this thesis is to identify issues within both the United States and United Kingdom healthcare systems to learn from each other. The main issues identified within the United States healthcare system are the exponential increase in costs for the government, hospitals, and patients, the fragmentation of the players within the industry (including the government, hospitals, physicians, and insurance companies), and that initiatives set out by the government are not reaching expected outcomes. The issues within the United Kingdom healthcare system are the aging population, patient access, increased wait times, overutilization by patients, and that the system is operating at a devastating financial deficit. The methods utilized are a literature review and personal interviews.

This work attempts to identify issues within each system and the reasons behind those issues. The secondary result is the potential ability to learn from some of the issues each country has had as our healthcare systems are becoming more similar. In the United States, we have recently begun to consider insuring more patients, possibly by expanding governmental insurance, which could lead us to run into some of the issues that the United Kingdom has seen by having every citizen insured. In the United Kingdom, the private market is becoming a larger factor, something that has always been present within the United States. As the United States looks to control the issues of cost, access, and quality, all while attempting to insure more patients, we can utilize many of the issues identified within the UK to understand what to watch for as we move towards a healthcare system more similar to what we see in the United Kingdom regarding expanded access.

Introduction

The primary motivation for this thesis is to compare healthcare structures and incentives in the United States and United Kingdom to find solutions to current industry challenges. The main challenges identified within literature pertaining to the United States are the exponential increase in costs for patients, providers, and the government, the

fragmentation of players within the industry (which include hospitals, insurance companies, and the government), and that the initiatives the healthcare industry is taking to improve quality and rising costs within healthcare are not effectively providing the outcomes many would have hoped.

Healthcare in the United States

A Public Broadcasting Service (PBS) clip titled “Money & Medicine” from 2012 highlights one of the main problems surrounding the increase in healthcare costs within the US. Early in the video it is stated that 30% of expenditures by American patients are for unnecessary services, costing around \$800 billion per year (PBS, 2012). A 2009 article by The New Yorker titled “The Cost Conundrum” focuses in on cost issues in a town in Texas, but can be applied to areas with similar demographics, of which there are many. It is stated that “the primary cause of McAllen’s extreme costs was, very simply, the across-the-board overuse of medicine (Gawande, 2009).” A Jama Network article shows us that in 2011, the US had healthcare expenditures of \$2.7 trillion, doubling since 1980 as a percentage of US gross domestic product (GDP) to 17.9% (Moses III et al., 2013). Comparing the United States to the rest of the world, in 2008, the per capita spending in the US was around \$7,500 while the next highest was Norway at almost \$5,000 per person (Squires, 2011). For reference, Norway’s healthcare system is completely publicly funded as part of the national budget through taxes, meaning that healthcare is primarily free at the point of service (Norway, 2008-2009).

Another substantial issue is the fragmentation of the main players within the healthcare industry, which include hospitals, insurance companies, and the government. Fragmentation refers to the fact that these key players often do not work closely or well with each other to deliver the highest quality care at the lowest possible cost to patients. One of the main points about the fragmentation in the industry is that insurance companies and hospitals are constantly engaged in a battle with the government. There is no one aggressor, as the government makes new laws and mandates for hospitals and insurance companies which in turn causes hospitals and insurance companies to do whatever necessary to maintain revenues, often going against those mandates that they see no

financial benefit in. For example, the American Recovery and Reinvestment Act of 2009 (ARRA) offered financial incentives for providers to adopt Electronic Health Records (EHR's). An EHR is a digital version of a patient chart which can be accessed in real time by users with login credentials. A fairly new concept in the world of healthcare, most healthcare systems currently utilize EHR's with varying levels of complexity, including data analytics to increase the patient experience. The monetary incentives to purchase and use an EHR range anywhere from \$12,000-\$44,000 per physician through Meaningful Use legislation (ARRA, 2009). While this sounds like a good thing at first, CMS also announced that penalties for not adopting an EHR will begin starting in 2015 (ARRA, 2009, Worzala, 2009). The penalties start at a loss of 1% in Medicare reimbursements in 2015 and go up by another 1% every year, ending at a maximum of 5% loss in Medicare reimbursement. Some physicians have chosen to take the penalties instead of attempting to implement an EHR system, which could potentially cost millions of dollars (Quinn, 2016).

Another issue with the US healthcare system is that initiatives that have been mandated by the government have not yet reached expected outcomes. One example is the implementation of EHR's as stated in the last paragraph. This mandate was a financial burden for providers and many did not see a correlation with increased quality (Quinn, 2016, Conn, 2014, Tahir, 2015). Michael Ciampi, a manager at a physician family practice said "The primary function was to enhance billing, not to build a physician-patient relationship. Our productivity went down 25 percent (Quinn, 2016)." Some of the reasons for this attitude toward EHR systems include a steep learning curve, trouble with IT support in rural areas, financial strain for smaller individual practices, and a lack of user friendliness (Quinn, 2016, Conn, 2014). Another example is the advent of value-based purchasing (VBP) and pay-for-performance (P4P). VBP and P4P are similar initiatives designed to improve quality, efficiency, and value in healthcare. Instead of following a traditional fee-for-service payment structure, they reimburse providers and hospitals based on patient outcomes rather than quantity of patients seen. While many studies cite an increase in quality under these new initiatives (Jha et al., 2012, Glickman et al., 2008, Werner et al., 2011, Gilmore et al., 2007), other studies and hospital executives state that while their quality has increased,

it had nothing to do with VBP (Evans, 2015, Binder, 2014). Other hospitals have tried to increase their quality, but since the VBP program does not consider certain factors in their measures of quality indicators, they are left at a disadvantage. One such factor is that the VBP program measures spending per beneficiary, but since patients with limited social and financial support might have to stay a few extra days in a nursing home or rehabilitation facility after hospitalization, hospitals with more of those types of patients are put at a disadvantage (Evans, 2015).

The United States healthcare system is most commonly described as a hybrid system, with no universal national health insurance coverage, single-payer system, or multi-payer universal healthcare fund. According to the Centers for Medicare and Medicaid Services (CMS), in 2014, 48% of healthcare spending came from private funds, 28% came from households, and 20% came from private businesses (CMS, 2016). In 2015, the Kaiser Foundation reported that 20% of the United States population was on Medicaid and 14% was on Medicare (Burns, 2014). The most recent major change in the healthcare system was enacted by President Barack Obama in 2010. This change came to fruition through a federal statute titled The Patient Protection and Affordable Care Act, usually shortened to the ACA. This statute initiated new provisions to be implemented in the healthcare system and outlined dates of provision enactment up until 2020. Some of the major provisions in the ACA are as follows: health insurers are no longer able to deny coverage based on preexisting conditions (enacted through The Health Insurance Portability and Accountability Act and amended through the Pre-Existing Condition Insurance Plan (PCIP), a precursor to certain provisions of the ACA), children can remain on their parents health insurance until the age of 26, everyone is required to purchase health insurance unless you qualify for an exemption with a non-compliance monetary penalty built in, individuals and families below 400% of the federal poverty line who purchase health insurance through a state exchange program will be eligible for a subsidy, the federal government will contribute to each state's Medicare budget as long as they abide by federal guidelines, and Medicare payments will begin transitioning from fee-for-service to bundled (Patton, 2013). Bundled payments are where the patient pays for an "episode of care" in one single payment instead of paying for

every service individually (Bundled Payments, 2017). In part due to this change, the percentage of the US population with health insurance reached 89.6% in 2014 (Smith & Medalia, 2015), compared to 85.4% covered in 2008 (Marken, 2016).

Healthcare in the United Kingdom

The National Health Service (NHS) was created in the United Kingdom in 1948 in the aftermath of World War II (Grosios, 2010). It was founded by the then Minister of Health, Aneurin Bevan, with the principles of universally free, point of delivery care paid for by central funding. While this system still stands today, the NHS of Wales broke off from the English system and became the responsibility of the Secretary of States of Wales in 1969. For the purposes of this literature review, whenever the NHS is mentioned, it will be regarding the NHS in England unless otherwise noted. The NHS is currently the largest provider in both England and Wales with 1.3 million and 70,000 employees respectively (Grosios, 2010, About NHS Wales, 2014). With the NHS providing universal health coverage and being funded through taxes, it is obviously structured very differently than healthcare in the United States. The taxes go to the United Kingdom government, who then decides how much to give to the NHS to care for its citizens. That money is then divided into regions known as trusts. In England, the NHS is separated from the government, while in Wales, it is still controlled by the Secretary of State. Some services are not provided for free under the NHS, including certain medications, chiropractic care, and certain eye and dentistry care. The fact that some services are not covered under the NHS led to the creation of private insurance companies, although these are much less prevalent than in the United States. These private insurance companies are mainly utilized by patients to receive care more quickly than through the NHS. When a patient gets sick, unless it is an emergency, they are instructed to go to their General Practitioner (GP), who is commonly known as the “gatekeeper.” A GP can handle minor issues, and some can even conduct simple surgical procedures. For the most part, GP’s are there to assess issues and act as a bridge between patients and specialists. If the problem is serious enough, they will refer a patient to a specialist or to a hospital (Royal College, 2011). It is important to know that the main

difference between the United States and United Kingdom is that in the UK, care is provided mostly for free at the point of service through the NHS.

The universal, government funded healthcare industry within the United Kingdom also has several drawbacks. The crucial issue is that the NHS has run out of money, but some other issues that go along with that problem are increasing wait times, overutilization, and an aging population (Today's NHS, 2017, Triggles, 2015, Challenges NHS, 2017). In the 2015/2016 budget year, the NHS saw a deficit of £1.85 billion (Dunn et al., 2016). One reason for this deficit is that public funding has not kept on pace with the demand for services. To go along with this, the NHS has hired more staff to increase quality of care after a report about failures of care in certain trust regions (Dunn et al., 2016). Between 2014 and 2015, the number of patients waiting more than 18 weeks to be seen by a GP went from 51,388 to 92,739, a 79.5% increase. This increase in wait times can be attributed to lack of beds, scheduling issues, and staffing problems (Patients Association, 2016). The root cause of increased wait time can be related back to financial problems. Wait times also correlate with overutilization, as the more patients that cannot be seen by their GP increases, so does the number of patients visiting Accident and Emergency departments (A&E) (Dunn et al., 2016). The third issue that relates to financial strain in the NHS is the aging population in the UK. With an increase in technology utilization and better management of chronic diseases, the life expectancy in the United Kingdom has increased from 70.81 years to 79.07 years from 1980-2014 (National Life Tables, 2015). These three issues all relate to each other, as an aging population means more patients (especially those utilizing more healthcare services (Institute of Medicine, 2008)) which means the system is strained to see all of their patients, resulting in longer wait times, which in turn increases the amount of utilization in A&E departments. Now is a critical time to examine the issues within the United States healthcare system due to nation-wide conversations about its structure. With the election of Donald Trump and his promise to repeal the ACA and replace it with something different, there are many questions as to what that restructuring will look like. A close examination of the different structures of United States and United Kingdom healthcare systems can potentially provide insight on how to mitigate the concerns of rising

costs and patient access to help identify what advantages one system might have over the other.

Patient Changes

United States

Since the inception of the NHS and Medicare and Medicaid, there has been much literature on the two countries that attempt to explain why certain players in the industry make certain decisions regarding patient care. The main players within the healthcare industry are patients, providers, hospitals, private companies, and the government. As mentioned previously, 89.6% of Americans had some type of health insurance in 2014. This is in contrast to only 85.4% covered in 2008 (Marken, 2016). While this might seem like a small percentage difference, consider that this means around 44.4 million Americans were without health insurance in 2008 versus only 33 million in 2014 (Marken, 2016). The most recent numbers by the National Center for Health Statistics put the number of uninsured Americans at as low as 27.3 million in the first quarter of 2016 (Cohen et al., 2016).

Recent changes for patients in the United States have included the shift from mostly inpatient services to outpatient services and the emergence of consumerism. A study by Kaufman Hall conducted between 2006 and 2011, encompassing almost half of the nation's population, saw a dramatic rise in the utilization of outpatient services over inpatient services (Grube et al., 2013). The researchers cite the reasons for this shift as: changes in medical practices that focus on coordinated collaborative care across the continuum, increased use of standardized care approaches to reduce care variation, care process redesign to reduce every bit of unnecessary work in all care settings, optimized service distribution to ensure the right care at the right site, and financial incentives of new value-based payment models that reward elimination of waste and redirection of patients to lower-cost settings (Kaufman, 2012). The Department of Health and Human Services reported a significant rise in the number outpatient visits from 1990-2000 (Bernstein, 2004). Recent articles by Becker's Hospital Review (Adamopoulos, 2014) and Healthcare Finance News (Zaino, 2014), show that the ratio of outpatient to inpatient services continue to rise. This reason for this trend is typically explained as hospitals, the government, and patients

attempting to take control of the exponential increase in the costs of healthcare. Studies have shown that shifting from inpatient to outpatient decreases the cost of care in some circumstances (Swanson, 2013, BCBS, 2016).

The rising trend in consumerism can also be attributed to patients attempting to take control of their own healthcare spending. The overarching idea of consumerism is to give consumers (patients) as much information as possible so that they can make the best decision about their healthcare and become more involved in their own self-care. This typically translates into patients being informed in two main categories: cost and quality. In the past, patients had no idea how much certain services would cost, especially in hospitals. While this trend is fairly new and has been introduced because of our increased use of technology, the outcomes of early adopters seem favorable. It has been noted that patients who engage in consumerism are generally healthier because they understand how certain decisions relating to their health impact how much they will spend on care (Healthcare Consumerism, 2013). One study on consumer-directed healthcare (CDHC) suggests that certain experiences are related to “favorable health selection, one-time reductions in use and costs, and mixed effects on quality (Buntin et al., 2006).”

United Kingdom

Recent changes in the NHS that have dramatically effected patients include the establishment of Healthwatch and the formation of Clinical Commissioning Groups (CCG's). These are both related to the Health and Social Care Act of 2012 passed under the UK Parliament. This Act will be discussed later in its entirety, but for now we will focus on these two certain provisions that effect patients in particular. Healthwatch is a group of organizations established to give a greater influence to patients of the NHS on how their care is given (Department of Health, 2012). These organizations are created at local and regional levels with the overseeing body being Healthwatch England. Healthwatch has many new initiatives set out for patients of the NHS including: building on strengths of the current system, addressing weaknesses, being a champion for diversity, and ultimately representing the voice of the local people (Department of Health, 2012). Healthwatch organizations will collect feedback form patients on the delivery of their care and design local services to

address patient needs. Their main goal is to be the voice of the common people in effecting decisions made by the government that change how their care is delivered. Healthwatch is the culmination of the concern that decisions regarding patients are being made at the national level without any actual patient feedback (Department of Health, 2012).

The formation of CCG's under the Health and Social Care Act of 2012 has many effects on healthcare in England. The main component that effects patient care is their contracting with private companies. CCG's are set up to "commission" services for patients of the NHS and to contract with different providers to deliver care. While they have typically contracted with NHS hospitals and government funded providers, they have also started contracting more with privately held care companies (NHS Support Federation, 2016). Studies on these contracts have shown that anywhere from 25% (for mental health services) to 86% (for pharmacy services) of services from 2010-2015 were awarded to non-NHS providers (Private Companies', 2016). In efforts to save money, logically the contracts will be awarded to those firms that can deliver the highest quality care at the lowest cost (Stone, 2016); however, quality of care through private companies has been shown to have some problems. Surveys published in 2015 found that private general practitioners delivered lower outcomes on 15 out of 17 quality indicators, including patient satisfaction and keeping patients out of hospitals (Problems with Outsourcing, 2016). Because of these quality issues, physicians have referred patients away from private facilities, NHS contracts have been terminated after low patient outcomes, and reports have been produced that show private providers altered performance records (Problems with Outsourcing, 2016).

The players in both the US and UK healthcare systems that cause changes for patients include hospitals, physicians, the government, and private healthcare companies. These players provide care for patients in each system and make decisions that change the way the system operates as a whole, with the governments themselves being the main driving forces. Each of these players and the decisions they make regarding how they operate will be looked at from three different angles: regulatory, cultural, and economic. These are the three frames that tend to drive decisions the most. Regulatory refers to decisions made by the governments that impact the laws that the different players must

follow to operate. Cultural refers to more of a historical aspect and how those players generally operate as a whole. Economic refers to the financial institutions in each healthcare system and how care is paid for. It also refers to market factors and how national economic forces drive decisions being made.

Literature Review

Hospitals

Regulatory/ Governmental – United States

To begin looking at what drives decisions for different players in the healthcare industry, we will first look at hospitals. The main factors identified that drive decision making for hospitals are regulatory, cultural, and economic. Governmental regulation has always played a big part in healthcare in the United States, evidenced by the creation of CMS and highlighted recently by the passing of the ACA. Regulation has in turn dramatically affected the way hospitals operate, and has caused some major changes. Some of those changes are the trend of hospitals buying physician practices, the formation of Accountable Care Organizations (ACO's), and EHR incentive programs. While hospitals were acquiring physician practices before the ACA was passed, there has been a dramatic increase since that time (MacDonald, 2016). The acquisition of physician practices can be attributed to some of the changes the ACA made, specifically certain provisions that incentivize narrower networks (Book, 2016). These changes give incentives to hospitals by setting up networks with non-Medicare insurance providers where a hospital and their affiliated locations are the main in-network providers. This consolidation can help ensure a certain population base and reduce competition at the individual provider level. Private practice acquisition is also related to the formation of ACO's under the Medicare Shared Savings Program (MSSP) through CMS (Book, 2016). The way an ACO works is that once one is established (by a hospital, group of hospitals, or another care provider), patients are then assigned to that ACO if that is where they spent the most amount of money on their care within the past year. Once the ACO has a population base set, the government decides how much it should cost to take care of that group of patients. If the ACO takes care of them for less money, then the two parties (ACO group and government) split the savings. The goal is obviously to

try to reduce costs. An attempt to reduce costs relates to hospitals acquiring physician practices because typically, although patients are seen more by physician practices, a single hospital visit could cost more than an entire year worth of physician practice visits combined. Thinking about how to lower the number of hospital visits, it is easier for an individual physician in a practice to monitor the health of a patient throughout the year. Many MSSP programs focus on keeping patients out of the hospital if possible, as a hospital visit costs exponentially more than a simple check-up.

The federal government has engaged in many initiatives to try to push hospitals and providers to adopt EHR systems. The American Recovery and Reinvestment Act of 2009 (ARRA) outlines monetary bonuses for hospitals that adopt EHR systems by 2014, with penalties starting at 1% of Medicare or Medicaid reimbursement in 2015. The bonuses range anywhere from \$12,000-\$44,000 and reimbursement cuts can go all the way up to 5%. To qualify, hospitals need to prove that they are meaningfully using the system, which the ARRA outlines as: a certified EHR product that demonstrates an ability to share data, the use of e-prescribing software, can exchange health information to improve coordination and quality of care, and can electronically report on quality of care (Worzala, 2009). In part due to this incentive program, the percentage of hospitals in the United States that have adopted at least a basic EHR went from 28% in 2011 to 84% in 2015 (Henry et al., 2016). This is especially significant in small and rural hospitals, who typically lag behind on EHR adoption. Their adoption rate was at 22% in 2011, with their 2015 rate being at 80%. Also significant, the rate of EHR systems with more advanced functionality has risen to 40% in 2015 versus 8.8% in 2011 (Henry et al., 2016). Now that the government has achieved a high level of EHR adoption, their 2015-2020 plan includes closing the gap on those remaining hospitals that have not adopted EHR's while also shifting to focus on coordinated care delivery and reform (Federal Health, 2016). Medicare reimbursement penalties could have potentially impacted the decision for hospitals to adopt and EHR more than the one-time financial incentives.

Regulatory/ Governmental – United Kingdom

One new minor regulation regarding hospitals in the UK is the required reporting of avoidable death numbers (Blame to learning, 2016) while other, more impactful governmental changes are the formation of CCG's and the establishment of the Care Quality Commission (CQC). CCG's, as explained before, are set up to "commission" services for patients of the NHS and to contract with different providers to deliver care, done regionally through the "trust" system. While trusts have typically contracted with NHS hospitals and government funded providers, they have also started contracting more with privately held healthcare companies (NHS Support Federation, 2016). CCG's have led to much of the money formerly funneled into the NHS now going to private companies (El-Gingihy, 2015). In 2014, out of £9.63bn worth of NHS deals signed, £3.54bn (nearly 40% of them) went to private firms (El-Gingihy, 2015). This means that while CCG's are legally required to provide emergency services and ambulances, much of the funding has now gone to private companies to deliver care. A survey of NHS patients showed that 68% would be in favor of increasing taxes by 1% if that money would go towards the financially unstable NHS (90). Relating to that same survey, 64% of those surveyed believed the services of the NHS were getting worse (Moore, 2017). Increases in private healthcare coverage has also raised concerns about creating a two-tier system, where patients that pay more money can skip through lines (Campbell, 2017). While this first happened with a private GP practice in February of this year, the fear is that many private companies will follow suit to increase financial performance. There are also fears of a loss of coordination in the healthcare system, as private companies threaten that idea with different ways of providing care and jeopardize the way in which care has always been delivered through the NHS (Campbell, 2017).

The CQC was created in 2009 for the purposes of regulating and inspecting healthcare services in England (Hospital Regulations, 2017). For hospitals to operate, whether publicly funded or private, they must be registered with the CQC. The CQC then monitors hospitals and attempts to produce yearly reports on hospitals and, in the case that quality standards are subpar, they make recommendations for changes (Hospital Regulations, 2017). Practically since their foundation though, they have been under

scrutiny. In November of 2009, the CQC chair resigned due to reports by independent sources that hundreds of people had died in a specific NHS trust due to appalling standards of care (Grover, 2009, Taskforce, 2009). These reports contrasted with a report filed earlier by the CQC stating that that specific trust had “good” quality of care (Taskforce, 2009). In 2013, a report came out alleging that there had been a “cover-up” within the CQC (NHS ‘cover-up’, 2013). Grant Thornton found that the CQC had deleted a reported failure to act on patient concerns about a certain NHS hospital (Cooper, 2013). The findings caused the new chairman of the CQC to say, “We can have no confidence, I think, not just at Morecambe Bay but across many more hospitals, that we have done a proper job (Cooper, 2013).” These reports foster ideas from the public that the NHS cannot be trusted, and by extension, the hospitals within that system (Cooper, 2013).

Culture – United States

There are many things that have driven the cultural shift of hospitals over the years, most of which is again the advent of consumerism and technology. Easy transportation is now widely available for much of the population and patients can compare hospitals in their areas through websites such as “CMS Hospital Compare.” Because of this, patients now decide where they have their treatment, something that was never thought about much before technology. Before then, people would typically go to whatever hospital was closest to them. They still do in more rural settings due to the limitation of options, but in urban settings, due to competition, there are more options to choose from as long as the physician you wish to see has admitting privileges. If they or someone they knew had subpar care, they might think about going somewhere else if the issue is not emergent, but will typically just try to get another doctor to perform the operation. At first, the quality shift was driven mostly by Medicare with the “Conditions of Participation” (McGeary, 1990), but since Medicare started publicly reporting their quality findings online in an easy and accessible way, patients are now more than ever shopping for the hospital with the highest quality and best prices (McClintock, 2014). This goes hand in hand with patient satisfaction, something else that is scored and rated on many hospital compare websites. Hospitals have started providing and participating in more community outreach and participation efforts.

While this effort could be linked to both regulation and economics, it is also a way for hospitals to get their brand out to the public to entice them to visit their hospital over others. While the opening of a hospital like Duke Children's Hospital in Durham might provide a needed service for the citizens of North Carolina, it also undoubtedly pushes the name of Duke Hospitals towards a more positive light, potentially drawing more patients towards affiliated care locations.

Culture – United Kingdom

The culture of hospitals in the UK have changed in the past few years to become more focused on the patient, specifically citing the need for the patient to be more involved in their care for patient needs to be met (Konteh, 2010). The NHS has also started to focus on patient safety, utilizing a shift from blame culture to learning culture (Ostrom, 2014, Blame to learning, 2016). The shift of NHS hospitals focusing more on individual patient feedback relates back to the formation of Healthwatch, local and national organizations designed for NHS patients to give feedback on their care. One study showed that before Healthwatch, 82% of patients would be willing to give feedback on their GP's performance but 46% did not know what way to do that (Feedback gap, 2015). The study also found that 71% of those did not know how to give feedback on maternity services and 68% did not know how to give feedback on mental health care (Feedback gap, 2015). Hopefully this trend will change, as Healthwatch and the NHS are actively trying to market this recent 2012 change. Currently, patients simply need to Google search their NHS trust region and "Healthwatch" to find the site to give feedback for their region, something that will be easily accessible for all citizens.

In 2014, the top United Kingdom health official spoke at Virginia Mason in Washington state and cited Virginia Mason's shift towards transparency as a driving force behind the NHS's shift to do the same (El-Gingihy, 2015). In this speech, Jeremy Hunt, the NHS official, cites a Virginia Mason patient that died due to neglect as a turning point for the transparency push by Virginia Mason. He compares that tragedy to one of neglect at the Mid Staffordshire system that was the turning point for transparency for the whole of the NHS. Virginia Mason patient Mary McClinton died due to a mix-up of injections and was

accidentally injected with antiseptic fluid instead of a harmless dye (Ostrom, 2014). Hunt stated that “Just as Mrs. McClinton’s death was a turning point for this one hospital, I want to make Mid Staffs a turning point for an entire health economy (Ostrom, 2014).” In this speech, he also announced a three-year plan to improve patient safety. This plan includes strongly urging hospitals to engage in “Sign up to Safety” programs, which allows them to publicize their plans for reducing avoidable tragedies. This shift towards patient safety is also related to a shift from blame to learning. In a speech at the Global Patient Safety Summit, Mr. Hunt outlines the instance where a new physician accidentally switched up two injections going into the same patient, causing the patient to die. Instead of addressing the organizational issues that led to the accident, the physician was prosecuted for manslaughter (Blame to learning, 2016). To stop these negative organizational responses from happening, the NHS needs to focus on how to fix these institutional issues rather than prosecuting individuals for accidents. One example he gives is that medication dispensing errors could lead to an opportunity for more clearly defined labeling (Blame to learning, 2016). Mr. Hunt said that starting in April 2016, England will become the first country to require hospitals to publish the number of avoidable deaths they had that year, an initiative hopefully leading to increased transparency and quality (Blame to learning, 2016). This will also hopefully cause hospitals with a high number of avoidable deaths to truly consider what causes these deaths, rather than blaming the individual or individuals that caused them.

Economic – United States

Economics have also played a large part in changing how hospitals operate. Some examples of what hospitals in the United States have done to try to create a better financial situation are engaging in population health initiatives (like ACO’s), acquiring physician practices, and consolidation. While participating in population health initiatives is not strictly government mandated, it is heavily pushed and incentivized. The largest example of a financially incentivized population health initiative is an ACO. While the main focus of an ACO is to deliver care at a lower cost to a set population base and split the savings, there are also some underlying factors that can contribute to increased finances. ACO’s give an

image that the health system participating in one is truly an institution of care and not just somewhere you go when something goes wrong. Because those facilities participating in ACO's are trying to manage patient care from a preventative standpoint, they typically have more contact with a patient than they previously did (Herman, 2011). This hopefully will lead to a patient realizing that that healthcare system personally cares about them and their health, which in turn would result in them receiving most or all of their care through that system when the time comes.

As stated before, hospitals have increased the rate at which they are acquiring physician practices since the ACA because of certain provisions that incentivize narrower networks (Book, 2016). Between 2012 and 2015, the number of physician practices owned by hospitals increased from 36,000 to 67,000, an almost 50% increase (Physicians Advocacy Institute, 2016). While this could be due to incentives for physicians, there are also incentives for hospitals. One incentive is that larger health systems have more negotiation power, whether that be locally with their own population, with insurance providers, or with the government (MacDonald, 2016, Hudson, 2013). Another reason again relates back to ACO's. As stated earlier, patients visit individual physician practices more than they visit hospitals. This means that it is easier to follow up with patients and monitor their health through a physician practice setting rather than in a hospital, something that helps with controlling costs. The trend in acquiring physician practices has also shown to have a positive effect on chronic disease management and quality of care, something that relates to larger reimbursements by CMS (Bishop et al., 2016).

Another trend we have seen hospitals engage in is consolidation. The reasons cited for this trend are the lowering of administrative costs, addition of service lines, and community considerations. In 2011, administrative costs accounted for 25% of hospital spending in the United States (Himmelstein, 2014). By consolidating, departments like billing and records can be significantly smaller and merge from two departments in different hospitals into one. Lowering costs by consolidation can also be applied to technology upgrades and infrastructure needs. In 2009, an American Hospital Association (AHA) study found that one in five hospital executives reduced services that lost money,

including behavioral health, post-acute care, and patient education (Ellis & Razavi, 2012). By spreading out fixed costs over wider revenue bases, hospitals can allow those larger revenue generators to compensate for those services that lose money. Consolidation can also be applied to quality measuring as well (Romano & Mutter, 2004). When hospitals can compensate for their lost revenue, they can begin to open new service lines that are needed within communities. Larger systems also encourage better integration and coordination of care between services provided at physician practices and different hospitals, something that is highly beneficial to the overall health of a community. Better care coordination from individual practices to hospitals is most likely due to EHR integration between practices and hospitals and ease of transfer, scheduling, and billing. In a study conducted in 2015, it was found that prices for private insurance were 15% higher in areas where hospitals had no competition (Cooper et al., 2015). While this might not necessarily be a good thing for patients and insurance companies, it increases revenues for hospitals.

Another trend in hospital operations has been towards employing Physician Assistants (PA's) and Nurse Practitioners (NP's) (Merritt Hawkins, 2013). This can be viewed as hospitals attempting to save money where they can, as PA's and NP's cost significantly less money but can clinically do most of what a physician does.

Economic – United Kingdom

Relating back to the formation of CCG's, the financial situation of hospitals in the NHS has declined in recent years (Sabin, 2015). With £3.45 billion out of £9.63 billion going to private healthcare companies, this means that significant amounts of money have been diverted away from NHS hospitals (El-Gingihy, 2015). NHS hospital trusts reported a £321 million deficit in the quarter before February 2015, with the total deficit reaching £2.54 billion in May 2016 (Sabin, 2015, Campbell, 2016). The financial strain is cited as an aging population, rise in long-term conditions, and a spike in A&E visits (Campbell, 2016, Stone, 2016). It was reported that A&E visits rose by 8% to 2.7 million patients in 2015 compared to 2013, with 570,000 of those being admitted for further treatment (Sabin, 2015). The declining financial situation of NHS hospitals has led some to claim that there is a lack of funding (Campbell, 2016) causing a Department of Health spokesperson to state in early

2015 that they will increase the NHS budget by £2 billion for the 2016 year (Sabin, 2015). In 2016, British Prime Minister Theresa May said that the NHS will receive an additional £8 billion in funding through 2020 (Rousseau, 2016).

There is not much that individual NHS hospitals can do to bolster their financial situation, as most of their funding comes directly from the NHS. Private hospitals, on the other hand, are operated as for-profit entities and can set their prices as they wish, since most patients utilizing their services either pay out of pocket or through private insurance. It is important to note that private healthcare companies have been growing in popularity. As stated before, £3.45 billion out of £9.63 billion worth of contracts in 2015 went to private healthcare companies, meaning that significant amounts of money have been diverted away from the NHS (El-Gingihy, 2015). Due to contracting with private healthcare companies and those facilities having less oversight than NHS hospitals, quality of care within private companies has been shown to have some problems. In 2013, the NHS stopped referrals to a specific hospital owned by a private company called BMI after a report showed that there were failings in consent, care, cleanliness, staffing levels, and quality monitoring (Problems with Outsourcing, 2016). The report also said that staff told inspectors that these failings were due to efforts to save money. An outsourcing company called Serco was found in 2013 to have overcharged the NHS £283,561 over a three-month period, amounting to a suspected loss of over £1 million in 2012 alone (Whittell & Dougan, 2014).

Hospital Comparison

Hospitals are highly regulated by the federal governments of both the US and UK, but the structure of incentive programs for each vary while attempting to achieve the same goals. Some of the goals that are similar for hospitals in both systems are attempting to lower costs while also increasing access. In the United States, this comes in the form of ACO's, which participation in has caused hospitals to buy physician practices and engage in population health. In the UK, this has come in the form of the creation of Clinical Commissioning Groups. Through these groups, trusts commission services for their patient base, more regularly with private services. The UK has also started to engage in public

health initiatives, although these are run mostly at the governmental level and not at a local level.

Incentives and mandates for hospitals in each country are different since most hospitals in the UK are government owned and the government can therefore make any decisions they want and implement them almost immediately. One example is EHR's. In the US, the government started to incentivize the use of EHR's and shortly after started introducing penalties. In the UK, since April 2015, all NHS hospitals and GP practices have an EHR and, if a patient is registered with a GP, a summary care record can be accessed by anyone with proper credentials (Health and care, 2016). A summary care record is a less detailed individual patient record that includes medications a patient is taking, allergies, name, address, date of birth, and a unique NHS patient identifier.

As the United States is attempting to shift to more patient focused care, so is the United Kingdom. In the US, ACO's and EHR adoption have been said to increase quality, but the main driving force behind the quality push is an attempted shift in payment structure. There are more government financial incentives to push quality rather than quantity on the hospital side. In the UK, the creation of the Care Quality Commission and Healthwatch have sent a message that the NHS truly is trying to increase the quality of care within their healthcare system.

The main differences relating to hospitals are the emergence of consumerism for patients in the United States and the utilization of private hospitals in the United Kingdom. While consumerism in the US is still a new concept because of the establishment of hospital compare websites, it will no doubt have a major impact on hospitals. Patients can now access quality and outcome data for hospitals and in some instances, can see prices for things like knee and hip replacement and procedural tests and scans. While this will most likely only affect metropolitan areas with more than one hospital, it will still have a drastic impact. In the UK, the NHS has started to contract with private healthcare companies at an unprecedented rate. Over one-third of contracts made by CCG's in 2015 went to private healthcare companies. This has in turn effected the money that gets put into NHS services, leading to low quality, increased wait times, and overutilization of A&E departments. Due to

these concerns, the British PM said that the government will put an additional £8 billion into the NHS by 2020.

Physicians

Regulatory/ Governmental – United States

There have been many governmental regulations and mandates that have changed the way physicians operate, including quality initiatives, changes to payment structure, and interventions. In 2006, CMS announced the Physician Quality Reporting System (PQRS) incentive program. This program formally ended in 2014 but the incentives under it have been carried on through the Value Based Payment Modifier program (VBPM). Under PQRS, an incentive of 0.5% increase in Medicare reimbursement was outlined with a 1.5% penalty for not reporting quality data (Physician Quality Reporting System, 2013). In 2013, 460,000 eligible physicians out of 1.25 million did not report quality data, while it was noted that 70% of those treated less than 100 Medicare patients that year (Beck, 2015). This lack of reporting by physicians is obviously tied to finances as well. If physicians must purchase an EHR system to report quality data, something that could potentially cost hundreds of thousands of dollars, versus losing up to 2% of revenue on less than 100 patients, it makes more financial sense to take a penalty rather than purchase this system. Quality reporting also takes a significant amount of time, something physicians cite as another reason that they haven't engaged in these initiatives (Beck, 2015). This has caused some to believe that physicians will start to phase out their Medicare patients all together to stop receiving penalties from CMS (Beck, 2015).

In early 2016, the Department of Health and Human Services (HHS) announced that they wanted to have 30% of Medicare reimbursements through Alternative Payment Models (APM's) by the end of 2016 and 50% by the end of 2018 (Better Care, 2015). The effort by CMS to shift from FFS to P4P is based mostly on the goal of containing costs within the healthcare industry. Under fee-for-service, physicians are reimbursed by the number of procedures they perform. This has led physicians to over utilize their own services, as 30% of healthcare spending in 2011 was on unnecessary services, costing about \$800 billion (PBS, 2012). The 30% spent on unnecessary services can also be attributed to patient

overutilization and increasing healthcare costs (Tuttle, 2016, Jaffe, 2017). Relating back to quality initiatives, because the tools to measure it are still in the early stages, physicians see more financial benefit in still operating under FFS rather than quality driven payment models. (Moses III et al., 2013) This has also led to many conflicts with being reimbursed under two payment models. One example is the challenge of attempting to increase volume under a FFS model versus reducing costs under risk-based contracts like capitation. Fully understanding the financial situation, physicians realized that the greatest marginal financial benefit was to increase “productivity” as measured by relative value units (RVU’s) through fee-for-service instead of engaging in quality reimbursement initiatives (Friedberg et al., 2015).

While forced interventions are not mandated by the United States government, there are laws in place that relate to physician negligence that can result in huge lawsuits to individual providers. Dr. Jerome Hoffman at UCLA School of Medicine talks about this issue in a clip titled “Money & Medicine (PBS, 2012).” He says that many things can “look” like cancer under a microscope, but most of those will not cause any harm. Given the slight chance that it does turn into cancer, physicians are basically forced to intervene out of fear of a lawsuit being filed against them for negligence in not treating it sooner. He specifically talks about prostate cancer, saying that if a prostate specific antigen (PSA) test is not ordered and the patient ends up with cancer, the patient will feel as if the physician did not do everything within their power to treat them and would most likely file a lawsuit. Even if the physician orders it and nothing shows up, the patient is still happy knowing they do not have any problems. This dilemma can relate to many fields of care and have caused a huge rise in overutilization.

Regulatory/ Government – United Kingdom

Many of the recent changes affecting physicians in the United Kingdom have come about since the passing of the Health and Social Care Act of 2012. The primary change was the abolition of Primary Care Trusts (PCT’s) and the formation of CCG’s. PCT’s were formed in 1999 with over 300 trusts operating in 2003 and divided up by regions throughout England (Health and Social Care Act 2012). Like CCG’s, they commissioned healthcare

services from NHS hospitals and facilities or private companies (Health and Social Care Act 2012). The main difference is that PCT's had a management structure consisting mostly of local leaders and a few care providers, while the management of CCG's consists mostly of GP's (Health and Social Care Act 2012, Chorley, 2012). The reason for a majority GP's led commissioning group is cited as an aim to give GP's the power to make decisions regarding their patient's care (Aziz, 2014). One important thing to note is that every GP practice within a given region is part of and has a say in decisions made by the group as a whole (Chorley, 2012). Since the formation of CCG's, they have come under scrutiny for a multitude of reasons. The main issue physicians and patients have with CCG's is that with only 211 groups as of 2014, with each seeing an average of 226,000 patients, the GP's are strained to see all of their patients (Chorley, 2012). Some physicians have claimed to see up to 40 patients a day, some of whom are very ill and require more time than usual (Chorley, 2012). The strain on current physicians has caused the General Medical Council to begin to recruit physicians from across Europe and provide easy access for them to operate in England (NHS England, 2017). In early 2017, the government promised to recruit more than 5,000 new GP's to England by 2020, including 500 from overseas (NHS England, 2017). In another effort to reduce the strain on GP's and patients seeking care, the English government announced a new plan in 2017 to incentivize practices to stay open 7 days a week rather than continuing the trend of most GP practices closing for either half or a full day per week (Smith, 2016). Another issue is the appointment of non-clinical staff to lead CCG's and the high salary received by those managers (Borland, 2015, Armitage, 2015). It was reported in 2012 that out of 81 groups that have appointed a manager to lead then, 50 have chosen a bureaucrat rather than a clinician (Borland, 2015). An online pay research service reported that in 2015, 56% of the 225 top executives were paying themselves more than the recommended salary of £95,000 to £125,000 a year, with one even making £280,000 (Armitage, 2015). Conflicts of interest have also come about on the board level of CCG's. In 2015, of the 3,392 CCG board members, over 400 were shareholders in private healthcare companies (Wooller, 2017). This raises concerns since these board members make decisions on contracts regarding care delivery.

In 2016, a plan was announced regarding the hours of junior doctors. This plan extended the normal working hours from 7am-7pm to 7am-10pm and included junior doctors working on Saturdays, something that had never been done before (NHS England, 2014). The announced plan also outlined a 10% increase in pay for hours worked overtime, a decrease from the 13.5% increase originally promised (NHS England, 2014). This caused the junior doctors to go on strike, causing a huge blow to patient care because there are 55,000 junior doctors in England, making up close to one-third of all clinicians (NHS England, 2014). The chair of the junior doctor's committee voiced her concerns about the changes, saying the new contract ""will have a direct impact on patient care" and "the government has no answer to how it will staff and fund extra weekend care (NHS England, 2014)."

Culture – United States

Physicians are undoubtedly the backbone of the healthcare industry. Much has changed for them recently and the decisions they make have been driven by cultural, economic, and regulatory factors. Much of the culture surrounding physicians comes from their many years of schooling but can also be traced back to the Flexner Report. In the late 1800's and early 1900's, Abraham Flexner conducted an international study focusing on the quality of medical schools in the United States and Canada. His findings showed that most medical schools were appalling based on their entrance requirements, medical equipment, and the relationship between medical schools and hospitals. The result of his study was the closing or consolidating of around fifty percent of the 155 medical schools in the United States and Canada at the time and an almost \$600 million donation to the endowments of medical schools by multiple organizations and foundations (Flexner, 1910). This obviously significantly reduced the number of physicians trained per year and started the psychological trend that physicians were at the top of the food chain as far as professions go (Bogle, 2012). During a physician's time in school, many begin to identify heavily with their profession, which focuses solely on delivering the best care to the patient (Raelin, 1991). When physicians are then thrust into an environment like a hospital with its many rules and intricacies, a conflict tends to arise between the needs of the organization versus the needs of the patient. Another example are the differences in the mentalities of hospital

executives and physicians. While executives tend to think about the organization and community as a whole, physicians have been taught to focus in on the individual patient that they are treating at the time (Lazarus, 1996). While this isn't necessarily bad for the patient, this leads to disagreements between physicians and managers (Lazarus, 1996). Executives see and understand that there are limited resources within organizations, but physicians tend to think that they should have unlimited resources, since hospitals are built to provide a setting for them to care for patients (Kinzer, 1959). The root of conflicts between managers and physicians is over professionalization, meaning that physicians often sacrifice the good of the organization for their specific profession, thinking that they should have every resource they need within reach (Bogle, 2012).

Another barrier that physicians face in an organization is the issue of autonomy. Again relating back to their education and training, physicians understand that they are at the top when it comes to decisions regarding patient care. Physicians flock into groups made up only of their own, something that is pushed further by hospitals having separate lounges for physicians and nurses. When physicians align with an organization, whether that be salaried through a hospital or operating their own practice that is affiliated with a hospital, they begin to clash with the idea of being an employee of someone else (Bogle, 2012). Because of their sense of autonomy, physicians tend to want to be able to operate without regulation and interference from others (Bogle, 2012). To go along with this, they also want to be evaluated based on their outcomes, not on their ability to conform to organizational rules (Bogle, 2012). This can cause physicians to become dissatisfied with their organization and employment, something that can lead to problems with quality and a strained relationship with their peers and organization (Raelin, 1991). This problem is highlighted by the relationship between physicians and the nurses they work with. One study shows that while 73% of physicians thought their rate of collaboration with nurses was high, only 33% of nurses thought the same about physicians (Schmalenberg, 2009). This relates back to physician autonomy and the underlying psychological notion that physicians are superior.

Culture – United Kingdom

The main differences between physicians in the US and UK is the way in which their career path goes once completing medical school and the differing ethics on patient care and what each would do in certain situations. Once a person completes medical school, they are a “junior doctor” for two years (Meyer, 2012). After that phase, a physician then decides whether they want to go the GP route or the specialist route based on their experiences in the first two years. If they decide to go the GP route, they will be known as a specialty registrar in a GP practice for three years before being referred to as a full general practitioner after five total years of experience following medical school (Meyer, 2012). If a physician decides to go the specialty route, they will be a specialty registrar in a hospital specialty for a minimum of six years before bumping up to the level of consultant after eight total years of experience following medical school (Meyer, 2012). Regarding ethical issues in healthcare, the biggest differences between physicians in the US and the UK were continuing treatment, unnecessary procedures, life-sustaining therapy, physician assisted suicide, providing information on other physician’s skills, and patient confidentiality (Doran, 2006). The questions and answers by physicians in the US vs. UK are as follows:

Question	US Physicians	UK Physicians
Would you ever go against a family's wishes to end treatment and continue treating a patient whom you felt had a chance to recover?	Yes: 23%	Yes: 57%
Is it ever acceptable to perform "unnecessary" procedures due to malpractice concerns?	Yes: 23%	Yes: 9%
Would you give life-sustaining therapy if you believed it to be futile?	Yes: 35%	Yes: 22%
Should physician-assisted suicides be allowed in some situations?	Yes: 47%	Yes: 37%
Would you inform a patient if he or she were scheduled to have a procedure done by a physician whose skill you knew to be substandard?	Yes: 47%	Yes: 32%
Is it acceptable to breach patient confidentiality if a patient's health status could harm others?	Yes: 63%	Yes: 74%

Adapted from Medscape 2012

The reasons for the differences in ethics are cited as different views towards patient-centeredness, medical liability climate, physician pay, religious attitudes, and the nature of physician relationships (Doran, 2006). The biggest difference is in the way the system is

funded. In the UK, most physicians work for the NHS, while in the US, most physicians work either independently or in privately operated hospitals (Doran, 2006). This means that most specialists in hospitals in the UK are salaried, while at the time of the survey (and still currently) most physicians in the US are paid through a fee-for-service system (Doran, 2006). There is also much less medical malpractice litigation within the United Kingdom compared to the US (Doran, 2006).

Economic – United States

Financial incentives for physicians are constantly changing in the US healthcare industry. While most physicians are still reimbursed under fee-for-service (FFS) (Lagasse, 2016, Terry, 2011, Rechteris, 2016), many alternate payments and financial incentives have arisen. There are many factors that go into how physician payment has been altered, most of which are the trend of physicians being employed by hospitals and changes to payment structure. From 2012-2015, the number of individual physicians employed by hospitals rose from 95,000 to 141,000 (accounting for 38% of total physicians) and the number of physician practices owned by hospitals rose from 36,000 to 67,000 (Physicians Advocacy Institute, 2016). The main reasons for this drastic increase in recent years can be attributed to a guaranteed salary, reduced administrative burden, and potentially even a higher income (Hudson, 2013). A guaranteed paycheck is a huge burden to be taken off, as physicians would not have to worry about how many patients they see within a month or a year, although it may still be a part of their annual review. This way, they can completely focus on delivering high quality care to patients. Administrative burden will also be taken away, as the hospital will not only oversee covering employee salaries but will also conduct all billing and record keeping, something that again takes off unneeded stress. A practice being acquired by a hospital could also mean a new EHR system. While the new system might take some getting used to, it takes off the strain of worrying about compliance with federal mandates. While having a higher income might not always be the case for a physician employed by a hospital, a slight pay cut would be welcome with the disappearance of other burdens of operating independently. In today's economic market, it is also much more risky to set up a new independent practice than to align with an existing

one or become employed by a hospital. The startup costs alone could cost millions with those costs being the acquisition of a building, payment of employees, the implementation of an EHR, and the purchasing of any medical equipment needed. After setting up a practice, it is especially difficult to generate a large enough patient base to quickly recover from those sunk costs.

While it is difficult to say exactly what percentage of physicians are reimbursed under FFS, there is no question that it is still the overwhelming majority (Lagasse, 2016, Terry, 2011, Rechteris, 2016). The remaining are paid through capitation, while many utilizing both FFS and capitation receive bonus payments through a pay-for-performance (P4P) model (Terry, 2011). In early 2016, the Department of Health and Human Services (HHS) announced that they wanted to have 30% of Medicare reimbursements through Alternative Payment Models (APM's) by the end of 2016 and 50% by the end of 2018 (Better Care, 2015). Examples of these alternative payment models are Comprehensive Primary Care Plus (CPC+), MSSP ACO Tracks 2 and 3, the Next Generation ACO model, and the Oncology Care Model. The effort by CMS to shift from FFS to P4P is based mostly on the goal of containing costs within the healthcare industry. Under fee-for-service, physicians are reimbursed by the number of procedures they perform. This would seem to lead to physicians conducting more services to increase the amount of money they generate. This is known to be true, as 30% of healthcare spending in 2011 was on unnecessary services, costing about \$800 billion (PBS, 2012). This is in part due to financial incentives for physicians as the more they do, the more they get paid. Physicians themselves even understand this issue. A general surgeon from McAllen, Texas said "There is overutilization here, pure and simple" and that doctors were racking up charges with extra tests, services, and procedures while not necessarily noticing that this was happening (Gawande, 2009). At some hospitals, physicians receive reimbursement for not only the services they provide but a share of the profits from a hospital's tests and other care provided, which can again lead to unnecessary services provided. Other studies say that because incentives for quality and the tools to measure it are still in the early stages, physicians see more financial benefit in still operating under FFS rather than quality driven payment models (Moses III et al., 2013).

It should also be noted that operating under two different payment models has challenges as well. In a qualitative study of physician practices, many reported facing conflicting incentives like attempting to increase volume under a FFS model versus reducing costs under risk-based contracts like capitation. This held especially true for hospital owned physician practices, in which reductions in hospital utilization (something highly incentivized under risk-based contracts) could take away from the financial well-being of the hospitals themselves (Friedberg et al., 2015). Even with a great deal of exposure to alternative payment models designed to reduce costs, the greatest marginal financial benefit for providers was to increase “productivity” as measured by relative value units (RVU’s), a unit of measurement originally intended for Medicare FFS contracts (Friedberg et al., 2015).

Another trend that emerged that could be due to economic factors is related to referrals. From 1999-2009, the likelihood that an ambulatory visit to a physician resulted in a referral went from 4.8% to 9.3%, a 94% increase (Barnett et al., 2012). This trend stayed consistent for all subgroups of physicians examined, excluding those physicians with ownership stakes in their practices. For this group of physicians, their referral rates only rose by 79% compared to a 136% increase in referral rates for those physicians without a financial stake in their practices (Barnett et al., 2012). This could reflect a financial incentive for physicians with an ownership stake to attempt to keep patients within their own practices.

Economic – United Kingdom

The main differences in economic incentives for physicians in the UK are due to the way their healthcare system is set up governmentally and financially. As stated before, the vast majority of specialists in hospitals are salaried (Doran et al., 2006). GP practices are typically owned by a group of 4 to 6 physicians and are paid primarily through contracts with the NHS (El-Gingihy, 2015). Through these contracts, 75% of physician pay comes from capitation while 20% is pay-for-performance and 5% is through the Quality and Outcomes Framework (El-Gingihy, 2015). In a 2004 financial incentive program, the NHS set aside £1.8 billion for a pay-for-performance program for family practitioners (Roland et al., 2012). The program showed promising results, as the practices combined scored 95.5% of the quality

points available for a total of a £76,200 bonus for each practice (Roland et al., 2012). The factors associated with that level of performance varied. Achievement was lower in practices with a high number of patients who lived in single-parent or low-income households or were 65 years of age or older (Roland et al., 2012). The achievement was also lower in large practices and those with a high number of practitioners who received their education outside of the United Kingdom or were 50 or older (Roland et al., 2012). In contrast, achievement was higher in practices with a better physician-patient ratio (Roland et al., 2012).

Privatization is another issue that affects physicians in both the hospital and private practice settings. Since 2010, 656 GP practices have merged, been taken over, or closed, usually due to poor financial performance based on under-funding (Campbell, 2015). This is no doubt due to the emergence of CCG's. In 2014, out of £9.63bn worth of NHS deals signed, £3.54bn (nearly 40% of them) went to private firms (El-Gingihy, 2015). This number shows that money has been diverted away from NHS hospitals and private practices with NHS contracts and have gone to private companies due to their ability to post lower costs for services (Stone, 2016). This has especially impacted smaller GP practices (Wilkin et al., 2001). With the decrease in funding to GP practices, many physicians have decided to retire earlier than expected (Hardy, 2015). Seventy-nine percent of those between the age of 55-59 said they intended to stop working while 82% of those aged over 60 said the same (Hardy, 2015). The reasons for early retirement were given as lack of funding while also facing an increased demand that has outgained their capacity (Hardy, 2015). Many of these older practitioners also say they are having trouble finding younger doctors to replace them, a daunting thought for the future of GP services in the NHS (Wilkin et al., 2001).

Physician Comparison

Both the US and UK governments have attempted to incentivize physicians to increase quality of care for patients. In the United States, the government has offered incentives for reporting quality data and has also attempted to change the payment structure of physicians by financially incentivizing quality over quantity, although many physicians still see more financial benefit in being paid based on quantity.

The NHS has also changed its structure to increase quality of care for patients, although in a much different way. The Health and Social Care Act of 2012 created CCG's, set up to regionally commission services for patients to reduce costs. CCG's are also important because they split services into regions, with GP's being the ones contracting for services. This logically makes sense because GP's know their local population and know the specific services they need better than the NHS would at the national level.

The culture of physicians in the US versus the UK seems to be only slightly different due to the differing culture of the two countries as a whole. In the US, physicians get paid a much higher wage, but in both countries, physicians are highly respected as they are seen to be doing a service. In the literature, it is mentioned that physicians in the United States can be arrogant and self-centered, but that seems to be changing along with the changing culture of the healthcare system. The system is becoming more patient and community focused, and again with the emergence of consumerism, patients who are treated poorly can simply change doctors.

Physicians in both countries are also changing their places of employment. In the United States, there is a trend of physicians either being employed by hospitals directly or their practices being bought by hospital systems, easing the administrative burden and improving care coordination. In the United Kingdom, many physicians are either retiring due to an inability to keep up with demand and strained financial situations or devoting more of their time to private healthcare in which they can pick and choose their patients in a more controlled setting.

Governments

United States

The federal government drives many of the decisions made by patients, hospitals, and physicians in the United States. The most recent major change in healthcare in the United States came in 2010 with the passing of the Patient Protection and Affordable Care Act (ACA). With the election of President Trump, the ACA has been threatened to be repealed, something that could cause even further changes and instability in healthcare in the United States (Jaffe, 2017). The ACA initiated new provisions to be implemented in the

healthcare system and outlined dates of provision enactment up until 2020. The goal and reasoning behind this federal statute was mostly cost containment, but also to provide affordable insurance to those without it and to increase the quality of care (72). In a 2009 speech at the White House, President Barack Obama said “By a wide margin, the biggest threat to our nation’s balance sheet is the skyrocketing cost of health care. It’s not even close (Gawande, 2009).” This quote is highlighted because in 2011, the US had healthcare expenditures of \$2.7 trillion, doubling since 1980 as a percentage of US gross domestic product (GDP) to 17.9% (Moses III et al., 2013). Comparing the US to the rest of the world, in 2008, the per capita spending was around \$7,500 while the next highest was at less than \$5,000 per person (Squires, 2011). In the goal of saving money, the ACA, along with other economic factors, has seemed to have done what it set out to do. A study published in June 2016 projected that the US is on track to spend \$21.1 trillion through 2019, a \$2.6 trillion savings compared to a 2010 projection of \$23.7 trillion through that same year (McMorrow & Holahan, 2016).

Another reason behind the passing of the ACA was the large number of uninsured citizens in the US at the time. In 2008, Obama’s first year in office, 44.4 million Americans were without health coverage (Marken, 2016). Recent studies put that number as low as 27.3 million in the first quarter of 2016 (Cohen et al., 2016). While the 17.1 million that became covered during that time are not all insured under Obamacare, it was announced in March of this year that another 12.2 million people were signed up to be covered under Obamacare in 2017 (Luhby, 2017). Wall Street analysts and consulting firms found that in 2013, 7 million people could qualify for paying zero monthly costs (Abelson & Thomas, 2013). These zero-payment subsidies are given to individuals whose income is at or less than 138% of the federal poverty level (making around \$16,000 a year) and families at the same rate (making around \$33,000 a year) (Amadeo, 2017). It was also estimated that in 2016, another 11.7 million qualified for any subsidy through Medicaid and Marketplace coverage (Garfield et al., 2016). Taking these numbers into consideration, it is safe to say that the ACA has exceeded expectations in helping millions of previously uninsured Americans find coverage.

The reason behind the quality push by the government was due to the low levels of quality at the time of the passing of the ACA. For example, between 2010 and 2013, over 50,000 less deaths occurred due to preventable errors and infections in hospitals than in the previous three years (Somander, 2015). Another example is the increase in quality due to ACO's as stated before. Studies have shown that patients engaged with ACO's have reported increases in experience, access, and coordination of care versus previous care delivery (McWilliams et al., 2014).

United Kingdom

As in the United States, the decisions made by the English government drives many of the decisions made by patients, hospitals, and physicians. The most recent major change in the healthcare system in England was the passing of the Health and Social Care Act in 2012. The Act creates many new changes for healthcare in England, with the major changes being the abolition of PCT's and the creation of CCG's, the creation of Healthwatch and Healthwatch England, the creation of Public Health England (PHE), and an increased focus on contracts with private healthcare companies (Martinez, 2016). The main reason the Act was passed was to address the daunting financial situation with healthcare in England (Today's NHS, 2017). Some of the factors that have caused this disheartening financial situation are increased wait times, overutilization, and an aging population (Today's NHS, 2017, Trigg, 2015, Challenges, 2017). Another main issue that came to light during discussions about this change were major failures of care in certain PCT regions throughout England (Dunn et al., 2016). Again, the root cause of these factors can be related back to financial issues. Wait times correlate with overutilization, as the more patients that cannot be seen by their GP increases, so does the number of patients visiting Accident and Emergency departments (A&E) to receive care (Dunn et al., 2016). CCG's were created to address the financial situation by allowing regional groups to contract with private companies to reduce costs (Stone, 2016). Since their formation and due to the increase in contracts with private companies, quality of care issues have arisen (Problems with Outsourcing, 2016). This issue leads into the reasoning for the creation of Healthwatch, a group or organizations established to give a greater influence to patients of the NHS on how

their care is given (Department of Health, 2012). Healthwatch has many new initiatives set out for patients of the NHS including: building on strengths of the current system, addressing weaknesses, being a champion for diversity, and ultimately to represent the voice of the local people (Department of Health, 2012). Another commission set up to monitor the quality of care in England is the Care Quality Commission (CQC), although this commission was set up in 2009 to conduct inspections healthcare services (Regulation and Standards, 2017). The CQC monitors hospitals and attempts to produce yearly reports on hospitals and in the case that quality standards are subpar, they make recommendations for changes (Regulation and Standards, 2017). The change with arguably the largest impact is the increased emphasis to contract with private companies. In 2014, out of £9.63bn worth of NHS deals signed, £3.54bn (nearly 40% of them) went to private firms (El-Gingihy, 2015). While the English government has undoubtedly put vast amounts of resources into healthcare reform, there are still many holes. Sir Malcom Grant, chairman of the NHS England, put it best when he said, “The NHS is the closest we British come to a national religion, which is good when it comes to ensuring it has enough resources, but not so good when it comes to reforming it (Kaiser, 2017).” Every single one of the initiatives set out within the Health and Social Care Act 2012 has been faced with reports of misuse and abuse, showing that for all of the good intentions, there is still a long way to go before the healthcare system in England operates like it was set out to.

Governments Comparison

The governments of both the United States and United Kingdom have both recently legislated major changes within their healthcare industries. In the United States, this was done to provide health insurance to those who could not afford it, to address exponential cost increases, and to further add to the quality push. In the United Kingdom, this was done to address quality, cost, and access. The Patient Protection and Affordable Care Act was passed in 2010 and outlined many new changes, mostly including new provisions for health insurance, Medicare and Medicaid, and payment models. This changed helped many previously uninsured citizens to become insured, but since then, there have also been many changes that might have been side effects of the ACA or simply market factors. Those

changes are increases in insurance premiums, increases in the number of High-Deductible Health Plans (HDHP's), and rising drug costs. One of the major changes was the formation and incentivizing of ACO's.

In the United Kingdom, the Health and Social Care Act of 2012 was passed and replaced Primary Care Trusts with Clinical Commissioning Groups, created Healthwatch, and created the Care Quality Commission. CCG's have had the biggest impact, as they are run by GP's at regional levels to commission services for their patient population, utilizing local knowledge of patient needs. Healthwatch and the CQC have so far done an adequate job of addressing patient quality and satisfaction concerns, although there has been abuse in terms of changing data to be more desirable.

Interviews

From December 30th, 2016 to January 13th, 2017, I conducted a series of interviews with healthcare providers in the United Kingdom. These interviews included a chiropractor, multiple dentists, an optometrist and a manager of a private hospital, all in England. In Wales, I interviewed a pediatric neurologist. Following those interviews, in the United States I interviewed a chiropractor and dentist as well. In the past, I have interviewed multiple hospital administrators and a nurse in the United States and believe those will be relevant as well. The reason for conducting these interviews was to get real, personal feedback from providers on different aspects of each country's healthcare systems to compare to what was found in the literature. Being that this paper is also about provider incentives, I asked many questions about why they and their healthcare system operate in the way that they do and the reasoning behind those incentives. For the interviews, I used a convenience sample of those providers available to me. In England, all of the providers were in Bury St. Edmunds, a town about 1.5 hours northeast of London. In Wales, the provider was located in the capital of Cardiff, but practiced all along the southern coast. In the United States, the providers were based in Boone, North Carolina, a town about 6 hours southwest of Washington, D.C. Within this section, it is important to keep in mind that what is presented here are the opinions of a few providers out of thousands and do not

necessarily represent the views of all providers. It is also important to keep in mind that while these interviewees are all professionals, there could be discrepancies in the facts they present.

Hospitals

United Kingdom

To learn about hospitals in the UK, I interviewed Melissa Cuevas (Cuevas, 2017), the manager of the BMI Hospital in Bury St Edmunds and Dr. Frances Gibbon (Gibbon, 2017), a pediatric neurologist at the University Hospital of Wales. BMI Healthcare is an independent provider of private healthcare but serves patients with private insurance, out-of-pocket, and NHS patients. In 2016, they operated 59 hospitals and clinics throughout the UK (About BMI, 2017) with £834.0 million in revenue in 2012 and £106 million in net income (Netcare, 2012). Through literature it was found that quality of care in private companies has been shown to have some problems. One example is that in 2013, the NHS stopped referrals to one specific BMI hospital after a report showed that there were failings in consent, care, cleanliness, staffing levels, and quality monitoring (Problems with Outsourcing, 2016).

While much of what I found in the literature about private healthcare in the UK seemed to be negative in the aspects of quality and the significant extent to which the NHS utilizes them now, the interviews presented much information on why patients tend to pay quite a bit more for care in private facilities rather than public NHS hospitals. The main reason found was that care in private facilities is much more relaxed. One example of this is that no BMI hospitals have casualty departments (Emergency Departments or Accident & Emergency) or intensive care units, therefore running at a less hectic pace. Patients are screened before care because of their lack of an intensive care unit, and they do not accept anyone that has comorbidities that could likely result in complications during surgery. The idea of a calmer care setting is backed up further by noting that when NHS overflow patients utilize the BMI facility, they typically note how quiet it is there compared to NHS hospitals.

The literature also stated concerns of lower quality of care in private facilities due to less governmental oversight. Because of the BMI Bury St Edmunds' contract with the local

trust, they do actually have to do internal quality audits for their corporate entity and because of their service agreement. Due to their close relationship with the local NHS hospital, where they send patients they cannot comfortably care for, they are required to do reporting much like that of the NHS itself. Not all BMI hospitals have this same relationship though, something that could have led to low quality reports in other facilities.

While not addressed much in the literature, the interviews presented a few ideas on why providers have started to shift to private work as well. Many providers have gone to work either partly or solely with private companies after they receive a pension through the NHS at around 25 years. The pension is very good and you could completely retire with it as your only revenue source if you wanted to. As stated earlier, many providers choose to work in private facilities because of the less strenuous environment compared to typical NHS facilities.

While Dr. Gibbon is not an administrator of an NHS hospital facility, she does have extensive experience working in one. She also spoke some on her experience with private care. Physicians who work in a hospital through the NHS are given “indemnity” through that hospital in case of a malpractice lawsuit. One of the major concerns about private facilities is that indemnity is not given, meaning any malpractice case against an individual is the sole responsibility of that individual. A case in a long-term care facility in England has led many providers to actually rethink their position on getting into private care. Concerns about access are still an issue for routine procedures, but the culture of medicine in the UK, and specifically Wales, has helped to mitigate those concerns. It was noted that while it might be more cost effective to build a few larger hospitals spread out by region, patients like care close to home, and therefore there are many small hospitals throughout the country, leading to easier access than if hospitals were more spread out. The NHS in Wales is holding up much better than the NHS in England, so much so that their pension funds are actually making money for the government through investments. There also has not been any private company contracting in Wales because their system is still financially sound.

Physicians

United Kingdom

For physicians in the United Kingdom, I interviewed two dentists, Dr. Pilcher (Pilcher, 2017) and Dr. Johnston (Johnston, 2017), a chiropractor, Mrs. Jacobs (Jacobs, 2016), and an optometrist, Mr. Wilbraham (Wilbraham, 2017). Routine dentistry and chiropractic care is not covered under the NHS, and only eyeglasses are for optometry (not contacts). Because of this, many UK patients have private contracts for these services or choose to pay out of pocket. “Usually [the] NHS is more for function not aesthetics because it is very low on funding.” (Johnston, 2017) Unfortunately, I was not able to interview any general practitioners, something I think is due to their schedule and high number of patients. Every GP practice I visited while trying to conduct interviews had packed waiting rooms, while many other practices I visited only had a few patients waiting at a time. This is also due to scheduling, as GP’s take mostly walk-ins while providers like dentists and chiropractors schedule by appointment. In the United Kingdom, doctors that operate on a more private basis and those that are not GP’s are able to set their own contracts with the NHS. This means that they can decide what kinds of patients they see. The dentists and optometrist see patients under the NHS that are under 19 and over 65, while the chiropractor only sees patients who pay out of pocket. The main reason cited for contracts being set up in this was that they wanted to care for the young and elderly. It was also mentioned that if you start seeing patients when they are young through the NHS, those patients will most likely stay with you when they pay out of pocket or through private insurance when they are older, leading to higher pay per visit. “I have more private patients because I don’t want to do any NHS dentistry. We only keep the children because they bring their parents with them.” (Pilcher, 2017) One of the dentists also mentioned that they were in the process of phasing out their NHS patients, meaning that they were not accepting any new patients due to the financial situation of the NHS and deteriorating payment. Another reason cited for providers having NHS patients is that they get a pension, even if they only see very few patients on the NHS side.

The reason these providers choose to operate in a more private capacity is due to clinical freedom, providing a “fuller” service to the patient. One reason for choosing to work

for the NHS rather than private is that you cannot pick and choose which cases you see, attracting those that want to test the limits of pathology and see more complex cases. Those within the NHS system also engage in clinical trials and research, something not done in private care. Under certain NHS contracts, you are only paid a certain amount for a set amount for time or certain procedures, sometimes causing sub-par care. These providers did state that they do everything necessary for a patient, but usually not far beyond that, and they even know some who only do the bare minimum as required by the contract. For the private contracts the dentists have, they are paid through a capitation scheme. For NHS contracts, they (and optometrists) are paid based on levels of care complexity, being reimbursed less for less complex services and more for more complex.

For payment, the individual providers within practices set their own rates through private contracts and out of pocket pay. For NHS contracts, all rates are set by the NHS. On the NHS side, as mentioned before, providers get paid per procedure based on the complexity. With private patients, providers can charge based on time, meaning that they are able to fully assess a patient better. All of the providers stated that they loved the concept of the NHS system, but because there are so many patients and a lack of funding, quality of care has gone down. With NHS patients, you are only reimbursed for a certain amount of time, so many providers try to squeeze everything in and it causes lower quality. The dentists gave some of the best feedback because they care for both NHS and private patients on a daily basis. They said that they receive anywhere from 3-5 times as much per procedure for private pay than with NHS.

There are many factors that go into the decision to work privately or with the NHS and to be a consultant rather than a GP. In the UK, a consultant is a fully-fledged doctor who has already gone through school and done their 2-5 years of apprenticeship. On becoming a consultant versus a GP, the decision largely rests on whether that person wants to be a specialist or see many different areas of medicine. There is not much difference in base pay, but for GP's, pay can vary greatly depending on how big their practice is and if it is private or not. Specialists mostly work for the NHS and can also boost and supplement their salary by working in private facilities as well. As stated before, there is also much greater

clinical freedom when working privately, again factoring into the decision. GP's, unlike most specialists, can choose to work part time to modify their hours how they wish, usually citing family life as the main reason. Even with the many factors affecting decisions made by physicians, they all still said patient needs were above everything else and that is what drives the decisions they make regarding patient care.

United States

In the United States, I interviewed Mr. Mark Torrie (Torrie, 2017), a chiropractor, and Dr. Mike Taylor (Taylor, 2017), a dentist. There are many similarities between the types of providers I interviewed in the United Kingdom and the United States, specifically the ones listed above. Providers such as these have started to phase out their patients that have governmental insurance, whether that be through the NHS in England or Medicare and Medicaid in the United States. Providers in both countries cite declining reimbursement and payment as the main factor, but also list other complications in dealing with the government, such as the amount of extra work that is required for quality reporting and billing. These providers that operate their own practices can choose which specific patients they see in both countries.

Since these types of providers seem to be shifting towards more self-pay or privately insured patients, the question is raised whether patients that have higher incomes utilize their services more often or get better care. Interestingly, dentists and chiropractors in both countries state that they see patients at all level of income. The reasoning behind this is that if patients truly value their health, they will pay whatever necessary. As expected, providers that operate their own practice independent of hospitals and the government can set their own prices for their services for self-pay patients. This again is another reason for shifting away from government insured patients. As found in the literature, there is a trend of providers in the United States no longer opening their own practices, instead choosing to align with an already established practice. The reason for this was also found to agree with the literature, with providers listing startup costs as too severe and "risky." The main difference between physicians that operate their own practice in the United States versus the United Kingdom is the use of advertising. While physicians in the US are free to

advertise through mediums such as billboards and television, physicians in the UK are regulated to only being able to advertise through word of mouth and an online presence.

Governments

United Kingdom

Many of the interviewees also conveyed opinions about the NHS as a whole from the physician and public standpoint. They all know that the NHS is strapped for money. One of the reasons the NHS is contracting more with private groups is that they can bundle many providers together into one contract instead of having to do many smaller contracts. This is where the quality concerns come into play. Companies like Specsavers employ hundreds of opticians within England and have contracts with the NHS. This has led to concerns because often, an optician will never see the same patient twice because they have to move around so much due to differing needs in certain areas. This means that patients never make connections with individual providers, causing a lack of coordination. Another example is Oasis dental who employ around 500 dentists. Negotiating contracts with these companies with many providers is less of a hassle for the NHS than contracting with individual dentists. Many providers are concerned with this because they also know another reason the NHS contracts with these companies is because they can undercut traditional costs, something they say must lead to lower quality as well.

Some of the decisions the NHS makes do not make sense to many providers. One example is the use of evidence based medicine. In the UK, physicians are not allowed to do any procedure or say they can do any procedure unless there is strong evidence and many studies done within the UK that prove it works. This usually helps provide patients with the best outcomes, but sometimes it falls short. One example is that of a 55-year-old world class cyclist who fell off her bike and broke her arm. When she went to the hospital, the first questions they asked her were whether her slippers fit properly, if she had handrails on her stairs, and whether her carpet was tacked down properly. These questions were asked because evidence shows that most people over 55 who have an injury similar to hers fall at home. This one example shows how the use of evidence based medicine in the UK makes providers tick boxes rather than reading individuals. Another example is the way in which

GP's refer patients. If a patient goes to a GP with a rash, they will refer them to a specialist, booking them with the first one with an availability. The problem with this though is that that specific specialist might only be a specialist in certain types of rashes, causing the patient to have to wait further to be sent to another specialist or even back to their GP. One practice that has emerged to negate the problem of referrals is a central triaging unit. In Middlesbrough, the NHS has set up clinics for certain issues where patients can go and have a nurse triage them and diagnose them, then sending them on to the proper specialist. Another systematic hardship for providers is the way in which they are reimbursed. While the US utilizes ICD codes, providers in the UK typically just write down exactly what they thought the issue was and how they treated it. This is both a positive and negative. It is positive because it avoids the confusion of multiple issues and how those fit together through codes. It is a negative because if there are many issues, the NHS then decides how the provider gets reimbursed, unlike a set rate with ICD codes.

From the patient side, I feel that it is important to note how much they pay in taxes. The basic tax rate in the UK is around 20%, with national insurance being around 11%, making taxes a total of around 31%. If you make over £60,000, the basic rate goes to 40% with insurance still being 11%. Once the £150,000 threshold is reached, you pay 45% basic tax but only 1% insurance. It was found both in the literature and in the interviews that many UK citizens would be in favor in an increase in taxes if it meant better care, access, and quality. Patients expect private care to be better than NHS care, mostly in the sense of cleanliness, timeliness, and more of a service industry rather than a public program. "We all think that it [the NHS] is an amazing principal, but it doesn't always work because of the cost of healthcare and the way that it can be and is abused." (Jacobs, 2017)

Findings & Discussion

Findings

The issues within the healthcare systems in the United States and United Kingdom are very similar. Both countries have issues with costs, access, and quality. In the United States, the cost of healthcare is the highest in the world. In the United Kingdom, the

government run and financed health system has simply run out of money and is operating at a devastating deficit every year. In the US, as more patients have become insured through the ACA, there has been pressure put on providers to care for all of the new patients. In the UK, with every citizen being automatically insured through the NHS, there has long been an issue with attempting to care for every patient. This problem has been exacerbated even further by the aging population, something that has also effected access in the healthcare system in the US. Both countries have also had issues with quality, something that has led to the US government to attempt a shift from a FFS to P4P payment model while also incentivizing other quality initiatives and has led to the formation of the CQC and Healthwatch in the UK. Both the US and UK recently passed system-wide legislation to improve on some of the concerns listed above. In the United States, the reasoning behind the passing of the Patient Protection and Affordable Care Act in 2010 was to insure more citizens, control costs, and further push quality. This change has led to more patients being insured, a push to shift from reimbursement based on quantity to reimbursement based on quality, and new programs such as ACO's, designed to increase access, improve quality, and reduce costs. In the United Kingdom, the Health and Social Care Act of 2012 was passed because of England's issues with cost, quality, and access. The main outcomes of this legislation were the abolition of PCT's and the formation of CCG's to address cost and access, and the formation of the CQC and Healthwatch to improve quality and safety. The largest issue in the UK is oversight. Being that the health system is government controlled, there have been issues with the top-down system and trying to oversee and regulate literally every aspect of their system. If the healthcare system in the US were to be completely government controlled, the larger population (5 times) and land area (40 times) would present a potentially even greater issue.

Discussion

The healthcare systems in the United States and United Kingdom are becoming more similar. As the United States is looking to insure more patients, possibly by expanding governmental insurance, they could run into some of the issues that the United Kingdom has seen by having every citizen insured. In the United Kingdom, the private market is

becoming a larger factor, something that has always been present within the United States. As the two systems become more alike, we can learn from, and potentially prevent some of the issues that have happened within the other system.

In the United States, if the healthcare system, specifically insurance, was to become government controlled and highly regulated, the US could potentially mitigate the issue of excessive costs with insurance. If this were to happen, more patients would become insured, something that could easily lead to the issue of access that we see within the United Kingdom. An increase in access would strain physicians even further to see the new influx of patients, possibly leading to physician burnout as seen in the UK, and quality issues. With the possibility of expanded government insurance, the United States could see a rise in certain specialties being paid for through out of pocket or private insurance. An issue to be wary of, that has been observed in the UK, is the way in which dentists, chiropractors, and other providers that mainly see patients who pay out of pocket or through private insurance are able to turn away patients. These forms of payment allow them to turn away patients that are deemed “too complicated or difficult to deal with.” If more patients were to be added to the US healthcare system without the addition of providers to see them, it could lead to the possibility of patients being pushed through quickly so that physicians are able to see everyone, potentially having a negative impact on quality. An issue with access could also lead to a problem of overutilization of emergency departments as seen in the UK. Essentially, if the US were to increase the number of insured patients, they would either need to increase the number of providers or possibly expand the range of care for lower-level providers such as PA’s, NP’s, RN’s, and CNA’s.

The idea of splitting the country into regions and having providers in that region assess the need of their patient population to better provide needed services is innovative, but could again lead to some of the same issues we have seen in the United Kingdom. The largest component of these regions is the GP. The thought of having a “jack of all trades” physician as a “gatekeeper” logically makes sense in certain aspects. The idea is that patients go to this physician with issues to be quickly assessed and possibly taken care of if it is a minor issue, not having to bother specialists with something a generalist can handle.

The issue here relates back to access. Citizens in the United States take it for granted that if they think they have an eye issue they can go directly to an optometrist, if they think they have a tooth issue they can go directly to a dentist, if they think they have a skin issue they can go directly to a dermatologist, and so on. Patients in the UK can do this to some extent if the issue is minor, but if the medical problem is more complex, they must be referred to a specialist in that area by a GP. The process of referrals has been found to be an issue in the UK, specifically relating to wait times and the fact that the specialist you are referred to might not be a specialist in that exact field of care. If you are referred to a specialist who cannot handle your specific issue, you are again directed back to your GP or another specialist, leading back to longer wait times.

The way that the United Kingdom budgets their healthcare is mainly through capitation. With this type of budgeting model, the issue of provider overutilization becomes less of a concern. In the United States, most providers still utilize a fee-for-service model that increases financial reimbursement with every patient seen and test and procedure conducted. These trends have been cited as one of the leading causes of the high cost of healthcare within the US. In the UK, because each region is budgeted a certain amount of money per year, most providers only do what is clinically necessary. Only doing what is clinically necessary helps with costs related to over utilization on the provider side, but if individual providers in the US were budgeted a certain amount of money per year and could keep the remainder at the end of the budget year, it could lead to issues of underutilization of clinically necessary care.

Limitations

There are a few limitations to this honors thesis that can be expected with any paper containing a literature review and personal interviews. For the literature review, many of the sources were online news articles, frequently excluding a list of sources. While the information presented in these articles is most likely correct, it was difficult to find the true, original source. With the intent of the literature review being to identify trends and potential issues in each country's health systems, once those trends were found, the search

for more sources could have limited the scope of the literature review to contain only those identified trends.

Pertaining to the interviews conducted, there were a few more limitations identified. Being that the interviews were conducted through the utilization of a convenience sample, the most noticeable limitation is the fact that the interviewees are not representative of all providers. The physicians interviewed are not representative of all physicians, even those within their field. This is also true for the hospital manager interviewed. There are also geographical and demographic limitations, as the physicians interviewed cannot be expected to fully understand the issues outside of their geographic and demographic scope. Since all but one of the interviewees from the United Kingdom was based in England, the experiences explained within the interview section will be skewed toward the healthcare system in England. Going along with that fact, the provider interviewed in Wales mentioned the healthcare system in England frequently, but cannot be expected to understand all of the intricacies within that system.

The final limitation is the scope of this thesis. While the government and insurance companies are listed as major players within the healthcare industry, I did not interview anyone in the governmental sector of healthcare. I also did not dive into insurance companies within the literature review, and therefore did not interview anyone from that sector either.

Contributions & Further Research

The research outlined in this work contributed an understanding of issues within the healthcare systems in the United States and United Kingdom. Another major contribution is the observation that, as the healthcare systems in the United States and United Kingdom become more similar, each country can potentially learn from and avoid many of the issues they have seen in the other system. With the US potentially expanding the number of insured patients and the cost of healthcare exponentially rising, we can learn from some of the issues that have already been addressed within the UK healthcare system. The largest potential issue has to do with access. As more patients utilize healthcare services, there must be research conducted on the potential impact to providers and patients. On a small

scale, the US can utilize some of the practices seen within the UK to attempt to study the impact of higher utilization by patients. Some examples of this would be assessing the impact on quality of care if more patients utilized healthcare services in a certain area. Within this study, we would need to watch for the effect on physicians with the potential of burnout and on patients with quality. The best way to address the cost issue in the US is to again conduct a small-scale study to assess the impact for providers and patients. If there was to be a study done addressing the effect of budgeting by a capitation-like model as seen in the UK, the US would know to watch out for the potential underutilization of clinical services and the impact that has on patient care and quality.

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